Complete Summary

GUIDELINE TITLE

Guidelines for the investigation of contacts of persons with infectious tuberculosis. Recommendations from the National Tuberculosis Controllers Association and CDC.

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention (CDC). Guidelines for the investigation of contacts of persons with infectious tuberculosis. Recommendations from the National Tuberculosis Controllers Association and CDC. MMWR Recomm Rep 2005 Dec 16;54(RR-15):1-47. [179 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE
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SCOPE

DISEASE/CONDITION(S)

Tuberculosis

GUIDELINE CATEGORY

Diagnosis
Evaluation
Prevention
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Internal Medicine
Pediatrics
Preventive Medicine
Pulmonary Medicine

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Health Care Providers
Nurses
Physician Assistants
Physicians
Public Health Departments
Respiratory Care Practitioners

GUIDELINE OBJECTIVE(S)

- To provide expanded guidelines concerning investigation of tuberculosis (TB) exposure and transmission and prevention of future cases of TB through contact investigations
- To discuss multiple related topics (e.g., data management, confidentiality and consent, and human resources)

TARGET POPULATION

Adults and children who are contacts of persons with infectious tuberculosis

INTERVENTIONS AND PRACTICES CONSIDERED

Evaluation and Assessment

1. Initiation of contact investigation
2. Investigation of index patient and site of transmission
3. Assigning priorities to contacts
4. Diagnostic and public health evaluation of contacts
5. Voluntary human immunodeficiency virus (HIV) testing, counseling, and referral
6. Tuberculin skin testing
7. Evaluation of children 5 years of age and younger
8. Evaluation of HIV infected or other immunocompromised contacts

Management/Prevention/Treatment

1. Treatment (for contacts with Mycobacterium tuberculosis infection)
   - Rifampicin
   - Isoniazid

2. Directly observed therapy
3. Monitoring for adherence to treatment and adverse effects
4. Use of enablers and incentives for treatment adherence
5. Expansion of a contact investigation
6. Communication through the media
7. Data management and evaluation of contact investigations
8. Ensuring confidentiality and consent
9. Staffing and training for contact investigation
10. Contact investigations in special circumstances
11. Source case investigations
12. Providing culturally appropriate patient care

MAJOR OUTCOMES CONSIDERED

- Incidence of tuberculosis (TB)
- TB infection rate in contacts
- Adherence to treatment

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

A working group consisting of members from the National Tuberculosis Controllers Association (NTCA) and Centers for Disease Control and Prevention (CDC) reviewed relevant epidemiologic and other scientific studies and established practices in conducting contact investigations to develop this statement. These published studies provided a scientific basis for the recommendations. Although a controlled trial has demonstrated the efficacy of treating infected contacts with isoniazid, the effectiveness of contact investigations has not been established by a controlled trial or study. Therefore, the recommendations have not been rated by quality or quantity of the evidence and reflect expert opinion derived from common practices that have not been tested critically.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Not stated

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RECOMMENDATIONS

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MAJOR RECOMMENDATIONS

Decision to Initiate a Contact Investigation

- The features of the tuberculosis (TB) case under investigation inform decisions about whether to perform a contact investigation (see Figure 1 in the original guideline document). An investigation (i.e., seeking and evaluating contacts) is recommended for the following forms of suspected or confirmed TB because they are likely to be infectious: pulmonary, laryngeal, or pleural TB disease with 1) pulmonary cavities, 2) respiratory specimens that have acid-fast bacilli (AFB) on microscopy, or 3) both.
- As time and resources permit and as recommended investigations are completed successfully, other pulmonary TB cases may be investigated if they are confirmed by culture of respiratory secretions.

- Pulmonary TB cases without positive mycobacteriology results should not be investigated unless circumstances indicate otherwise (e.g., if mycobacteriologic results are absent because of an error or if a priori information raises suspicion that contacts have been infected).
- The only forms of purely extrapulmonary TB (i.e., cases without pulmonary disease) that should be investigated are laryngeal or pleural disease. For other forms, source case investigations can be considered under special circumstances (see section below titled "Source-Case Investigations").

Investigating the Index Patient and Sites of Transmission

- Written policies and procedures for these tasks improve uniformity and efficiency.
- Tasks should be assigned to trained and experienced public health workers.
- Interviews should be in the index patient's primary language and be conducted by persons fluent in that language or in conjunction with fluent interpreters.
- The index patient should be interviewed in person (i.e., not by telephone) ≤ 1 business day after notification for cases indicating infectiousness and ≤ 3 business days for others. For patients who have died or who are inaccessible, alternative sources of information regarding contacts should be sought.
- The place of residence for the index patient should be visited ≤ 3 business days of initiating the contact investigation.
- All potential settings for transmission should be visited ≤ 5 working days of initiating the contact investigation.
- The contact list and priority assignments (see below "Assigning Priorities to Contacts") should be written into an investigative plan.
- Information regarding the index patient should be reassessed at least weekly until drug-susceptibility results are available for the Mycobacterium tuberculosis isolate, for 2 months after notification, or until infectiousness has diminished, whichever is longer.
- At 1-2 weeks after the first interview, the index patient should be interviewed again as necessary for clarification and additional information.

Assigning Priorities to Contacts

- Priorities for ranking contacts for investigation are set on the basis of the characteristics of the index patient, the duration and circumstances of exposure, and the vulnerability or susceptibility of the contact to disease progression from M. tuberculosis infection.
- The optimal exposure cut-off durations for assigning priorities to contacts have not been determined because available data lack this level of precision. The National Tuberculosis Controllers Association work group did not reach consensus on cut-off durations. On the basis of local experience and adjusting for resource limitations, public health officials should set local standards for the durations of exposure that define high, medium, and low priority.

Diagnostic and Public Health Evaluation of Contacts

General

- Health departments are responsible for ensuring that TB contacts are medically evaluated and treated.
- Communicable disease regulations or laws in certain jurisdictions apply to contacts who are not responsive to requests to be examined. The least restrictive means should be applied first.
- Each high- and medium-priority contact should be assessed initially ≤ 3 working days after being listed.
- Each high- and medium-priority contact should be evaluated medically to determine whether TB disease and latent infection with M. tuberculosis are present or absent.
- The same diagnostic methods are recommended for all contacts except when they have medical or constitutional conditions making TB more likely or more difficult to diagnose. A contact's country of origin and Bacille Calmette-Guérin (BCG) vaccination status are not included in algorithms for diagnosis or treatment.

Voluntary Human Immunodeficiency Virus (HIV) Counseling, Testing, and Referral

- Inform all contacts that HIV infection is the greatest known risk factor for TB disease progressing from M. tuberculosis infection, and ask whether they have been tested for HIV infection.
- Offer voluntary HIV counseling, testing, and referral to TB contacts who do not know their HIV infection status. Collaboration with HIV-acquired immune deficiency syndrome (AIDS) programs is recommended for establishing systems that are convenient and flexible for patients.
- Voluntary HIV counseling, testing, and referral are recommended for contacts of HIV-infected infectious TB patients.

Tuberculin Skin Testing

- A tuberculin skin test (TST) is recommended for all contacts who do not have a documented prior positive test result or documented prior TB disease. The skin test can be administered at the time of the initial assessment. High priority contacts should receive a test ≤ 7 days after they are listed, and medium-priority contacts ≤ 14 days.
- A two-step TST as defined for infection control surveillance is not recommended for contact investigations.

Evaluation of Children Aged <5 Years

- Contacts aged <5 years exposed to an infectious index patient are assigned a high priority.
- Contacts aged <5 years should be medically examined and have a chest radiograph regardless of the result of the current or prior skin tests or history of prior TB disease.

Evaluation of HIV-infected or Other Immunocompromised Contacts

- HIV-infected or other immunocompromised contacts are high-priority contacts.

- In addition to a medical history, examination, and a TST, a chest radiograph is recommended for all these contacts. Sputum collection for acid-fast bacilli (AFB) microscopy and culture is recommended if the contact has symptoms consistent with TB disease or if the chest radiograph has abnormalities that could be caused by TB.

Any Contacts Being Evaluated

- Contacts who have a positive TST result ($\geq$5 mm) should be medically examined, including a chest radiograph, to rule out TB disease. Contacts who have symptoms consistent with TB also should be medically evaluated, including a chest radiograph, to rule out TB, regardless of the results of the skin test, history of a prior positive result, or history of prior TB disease.
- During the infectious period, those high- and medium priority contacts who have a negative skin test result <8 weeks after their most recent exposure should have a second skin test 8-10 weeks after that exposure.
- For low-priority contacts, the initial skin test may be delayed until 8-10 weeks after the most recent exposure if the contact does not have symptoms suggestive of TB disease. If the test is administered <8 weeks after the most recent exposure, the decision to give a second, postexposure skin test can be made on a case-by-case basis.

Treatment for Contacts with M. Tuberculosis Infection

- Treating contacts who have latent M. tuberculosis infection through completion is a health department responsibility to prevent communicable diseases.
- High- and medium-priority contacts with positive TSTs who come from countries with prevalent TB should be treated, regardless of whether they have had routine BCG vaccination.
- Treatment for latent infection should be offered to all contacts who have a positive tuberculin skin test result, after active TB is excluded. The emphasis of the program should be on completing treatment in high- and medium priority contacts.
- Window-period prophylaxis (see section above entitled "Diagnostic and Public Health Evaluation of Contacts") is recommended as an option for contacts aged <5 years who have a negative skin test result <8 weeks after the end of exposure, after TB disease has been excluded. If a second skin test result 8-10 weeks after the end of exposure is negative, treatment can be stopped.
- A full course of treatment for presumptive M. tuberculosis infection is recommended for HIV-infected or otherwise notably immune-suppressed contacts, after TB disease has been excluded, even if skin test results are negative >8 weeks after the end of exposure.
- The decision to treat contacts who have documentation of a previous positive skin test result or TB disease should be made on an individual basis. Treatment is recommended for HIV-infected contacts in this category, even if infection has been treated previously.
- Rifampin treatment is recommended for contacts who, after TB disease has been excluded, have infection presumed to be isoniazid (INH)-resistant, rifampin-susceptible M. tuberculosis after exposure to an index patient with such an isolate.

- Expert consultation is recommended for selecting treatment for a latent infection with presumed INH- and rifampin-resistant M. tuberculosis. Contacts with such an infection should be monitored with periodic examination for at least 2 years.
- Directly observed therapy (DOT) for latent infection is preferred over self supervised. DOT preference should be assigned to these groups, in this general order:
    - Confirmed or suspected TB disease
    - Latent M. tuberculosis infection in contacts aged <5 years
    - Latent M. tuberculosis infection in contacts who have HIV infection or other conditions that limit immune response to TB
    - Latent M. tuberculosis infection in contacts with documented change in tuberculin sensitivity, from a negative to a positive result
    - Latent M. tuberculosis infection in contacts who might not complete treatment because of social or behavioral impediments (e.g., alcohol addiction, chronic mental illness, injection-drug use, unstable housing, unemployment)
- Monitoring for adherence and adverse effects by home visits, pill counts, or clinic appointments monthly or more often is recommended for contacts on self-administered treatment.
- Use of enablers and incentives and establishment of a positive rapport with contacts who are taking treatment are recommended for enhancing adherence.

When to Expand a Contact Investigation

- Inclusion of lower-priority contacts generally is not recommended unless objectives for high- and medium-priority contacts are being met.
- Consider expanding the scope (i.e., number of contacts) of an investigation if any one or more of the following criteria exist:
    - Unexpectedly large rate of infection or TB disease in high-priority contacts
    - Evidence of second-generation transmission
    - TB disease in any contacts who had been assigned low priority
    - Infection in any contacts aged <5 years
    - Contacts with change in skin test status from negative to positive
- After reviewing the results from the investigation to date (i.e., for high- and medium-priority contacts), select the additional contacts by extrapolating the risks for infection as shown by the data.
- When results from an investigation indicate that it should be expanded, but resources are insufficient, seeking assistance from the next higher public-health administrative level is recommended.

Communicating Through the Media

- Anticipatory media communication (e.g., with a press release) for large or highly visible TB contact investigations is recommended to capitalize on the opportunity for constructive public communications.
- Coordination of media communications, both within the health department and with collaborating partners outside the health department, improves the clarity and consistency of media messages.

- For efficiency, use of media message templates for contact investigations is recommended.

Data Management and Evaluation of Contact Investigations

- Collection of specific data elements on index patients and their contacts is recommended. The data elements should permit calculation of program performance indices.
- Data should be collected on standardized (paper or electronic) forms.
- Data definitions and formats for use by persons who collect, use, and interpret contact investigation data are recommended.
- Whenever feasible, data definitions and formats should be standard among jurisdictions.
- Electronic data storage is recommended for quick analysis of interim results.
- Policies for data management and storage are recommended, with assignment of responsibilities.
- Training and policies for data accuracy, completeness, and security are recommended. Part of a staff-person's time should be dedicated to reviewing and monitoring contact investigation data.
- Periodic summarization and review of data are recommended during a particular contact investigation and overall.
- Program evaluation for contact investigation activities, at least annually, is recommended. It is an integral part of TB program responsibility.
- Beyond standard data elements shown in these guidelines, specific additional elements can contribute to local program management.

Minimal Recommended Data Concerning the Index Patient

Identifiers and demographic information

- Case manager
- Name and aliases
- For minors and dependents, guardian information
- Date of birth*
- Social security number
- Current locating information and emergency contacts
- Residences during infectious period if unstably housed
- RVCT number* and local case number
- Sex*
- Race*
- Ethnicity*
- Country of birth*
- If foreign born, length of time in United States*
- Primary language and preferred language
- Methods of translation or interpretation

Settings in which index patient might have transmitted tuberculosis (TB) and associated timeframes

- Living situation(s)
- Employment or school

- Social and recreational activities
- Congregate settings (e.g. jail or homeless shelter)*
- Substance abuse with social implications (e.g., crack cocaine)*

TB information

- Health-care provider for TB (e.g., public health, private, both, other)*
- Anatomic site of disease*
- Symptoms and their dates
- Chest radiograph results, including presence of cavity*
- TB medications with start and stop dates*
- Bacteriologic results (sputum smear, culture, and drug susceptibility) with dates*
- Previous history of TB disease and treatment*
- Previous history of exposure to other persons diagnosed with TB
- Infectious period (updated as new information arrives)
- HIV infection status*
- HARS** number

Contact investigation

- Date of initial interview with index patient
- Dates of follow-up interviews with the index patient

*Data items collected on the Report of a Verified Case of Tuberculosis (RVCT) form.
**HIV/AIDS Reporting System.

Minimal Data Recommended Concerning Each Contact of Persons with TB

Investigator and dates

- Contact manager or investigator
- Date listed
- How or why contact was listed (e.g., named by index patient)
- Dates of interviews
- Start and end dates for exposure (updated as new information arrives)

Identifiers

- Name and aliases
- For minors and dependents, guardian information
- Social security number
- Date of birth
- Locating information and emergency contacts
- Sex
- Race
- Ethnicity
- Country of birth
- If foreign born, length of time in the United States
- Primary language and preferred language

- Methods of translation or interpretation

Relationship or connection to index patient

Social affiliations (e.g., work, school, church, clubs, or activities)

Environmental information about exposure settings (e.g., size or ventilation)

Frequency, duration, and time frame of interactions

Previous history of TB disease or latent infection, and documentation

Bacille Calmette-Guérin (BCG) vaccination and date

Medical risk factors for progression of infection to TB disease*

Population risk factors for prevalent Mycobacterium tuberculosis infection*

Evaluation for TB disease and latent infection

- Health-care provider for TB (e.g., public health, private, both, or other)
- Symptoms suggesting TB disease
- Tuberculin skin tests, with dates, reagents, and lot numbers, and reaction measurement
- Chest radiograph results with dates
- Bacteriologic results with dates
- HIV infection status
- Final diagnostic classifications for latent M. tuberculosis infection or disease

Treatment information for contacts with latent M. tuberculosis infection

- Dates of treatment
- Treatment regimen (medication, dosing schedule, and any changes to these)
- Methods of supervising treatment (e.g., directly observed treatment.)
- Adverse effects (specify each)
- Interruptions in regimen and dates
- Outcome of treatment (e.g., completion, consistent with ARPE*)
- If treatment not completed, reason*

* Aggregate report for program evaluation.

Confidentiality and Consent in Contact Investigations

- Specific policies for release of confidential information related to contact investigations are recommended. These policies should be consistent with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Sections 306 and 308(d) of the Public Health Service Act and be developed in consultation from health department legal counsel. These policies typically include instructions for obtaining consents and for breaking confidentiality when required for public health as authorized by laws.

- Patient confidentiality is a core element integrated with all activities in contact investigations, and training in its laws and practice is recommended for all personnel who participate.
- Discussion with the index patient and contacts regarding their confidentiality beliefs and concerns is recommended. TB control program staff should explain to the index patient the measures that will be taken to maintain confidentiality.
- Preparations for protecting confidentiality are recommended for each site visit during an investigation. Anticipatory discussions with any patients who might be affected contribute to the preparations.
- Confidentiality applies to all private information and medical conditions in addition to TB.

Staffing and Training for Contact Investigations

- Certain functions in contact investigations require state licensure. Delineation of these functions is recommended for preparing personnel position descriptions.
- Specialized functions and related skills are needed during contact investigations; they might be provided by sources outside of the health department (see Box 3 in the original guideline document).
- Preparatory training and detailed on-the-job supervision as each function is encountered by new health department personnel establish the basis for expertise.
- Direct observation by experienced personnel and opportunities for practicing skills are essential when any personnel assume new functions for contact investigations.
- Clerical personnel, receptionists, and managers who help with contact investigations need to understand the overall purpose and methods of contact investigations.
- When sources outside the health department serve essential functions in a contact investigation, the health department is responsible for assessing whether the skills are sufficient and offering training so that the functions are met correctly.

Contact Investigations in Special Circumstances

- A cluster of TB cases (i.e., a presumed outbreak) indicates potential lapses in TB control which should be investigated along with the outbreak. Assistance should be requested if the scope of the investigation exceeds local capacity or disrupts key activities of TB control.
- When secondary TB cases are discovered unexpectedly (e.g., outside of a contact investigation), this indicates a potential outbreak. Review of the investigative strategy is recommended.
- When contact investigations include congregate settings, officials or administrators at the setting should be enlisted as collaborators. Access to employee and occupancy rosters should be sought. Sensitivities and needs of the setting and its populace should be accommodated to the extent permitted by good public health practice.
- When few contacts are listed because information cannot be obtained from an index TB patient, alternative or proxy methods, such as interviews in the extended social network, are recommended.

- Contact investigations for multidrug-resistant TB do not require a change in procedures, but the reasons for the drug resistance should be explored.
- Interjurisdictional contact investigations should be planned collaboratively from the inception. Assistance in coordinating such investigation should be sought from the next higher public-health administrative level.
- Unusual exposures to M. tuberculosis-complex, such as laboratory accidents or tuberculous animals, should be investigated on site, and contacts should be selected in accordance with the event, in consultation with subject matter experts.

Source-Case Investigations

- Source-case investigations are not recommended unless investigations of infectious cases have been successfully completed and program objectives for investigating contagious patients and treating their infected contacts are being met.
- Source-case investigations, if conducted, are recommended for TB disease in children aged <5 years.
- Data on source-case investigations should be reviewed for determining the value of these investigations in the local context.
- Searching for a source of unexplained latent M. tuberculosis infection is not recommended, and if conducted, should be reserved for infected children aged <2 years.

Other Topics

Cultural Competency

- Systems for providing culturally and linguistically acceptable care during contact investigations are recommended.
- Training in cultural and linguistic sensitivity is recommended for personnel who conduct contact investigations.

Social Network Analysis

- The methods of social network analysis are recommended for further research. However, certain concepts (e.g., setting-based investigations) are also applicable to current efforts.

CLINICAL ALGORITHM(S)

Clinical algorithms are provided in the original guideline document for

- Decision to initiate a tuberculosis (TB) contact investigation
- Prioritization of contacts exposed to persons with acid-fast bacilli (AFB) sputum smear-positive or cavitary tuberculosis (TB) cases
- Priority assignments for contacts exposed to persons with acid-fast bacilli (AFB) sputum smear-negative tuberculosis (TB) cases
- "Prioritization of contacts exposed to persons with suspected tuberculosis (TB) cases with abnormal chest radiographs not consistent with TB disease

- Evaluation, treatment, and follow-up of tuberculosis (TB) contacts aged <5 years
- Evaluation, treatment, and follow-up of immunocompromised contacts
- Evaluation, treatment, and follow-up of immunocompetent adults and children aged >5 years (high- and medium-priority contacts)
- Evaluation, treatment, and follow-up of low-priority contacts
- Evaluation, treatment, and follow-up of contacts with a documented previously positive tuberculin skin test

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The working group reviewed relevant epidemiologic and other scientific studies and established practices in conducting contact investigations to develop this statement. These published studies provided a scientific basis for the recommendations. Although a controlled trial has demonstrated the efficacy of treating infected contacts with isoniazid (INH), the effectiveness of contact investigations has not been established by a controlled trial or study. Therefore, the recommendations have not been rated by quality or quantity of the evidence and reflect expert opinion derived from common practices that have not been tested critically.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

The direct benefits of contact investigations include 1) finding additional tuberculosis disease cases (thus potentially interrupting further transmission) and 2) finding and treating persons with latent tuberculosis infection.

POTENTIAL HARMS

False negative QuantiFERON®-Gold tuberculosis test result

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

These guidelines do not fit every circumstance, and additional considerations beyond those discussed in these guidelines must be taken into account for specific situations. For example, unusually close exposure (e.g., prolonged exposure in a small, poorly ventilated space or a congregate setting) or exposure among particularly vulnerable populations at risk for tuberculosis (TB) disease (e.g., children or immunocompromised persons) could justify starting an investigation that would normally not be conducted. If contacts are likely to become unavailable (e.g., because of departure), then the investigation should receive a higher priority. Finally, affected populations might experience exaggerated concern regarding TB in their community and demand an investigation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Recommendations for staffing and training for contact investigations, for data management and evaluation, and for data collection and storage are provided in the "Major Recommendations" section of this summary and in greater detail in the original guideline document.

IMPLEMENTATION TOOLS

Clinical Algorithm
Staff Training/Competency Material

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness
Timeliness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Centers for Disease Control and Prevention (CDC). Guidelines for the investigation of contacts of persons with infectious tuberculosis. Recommendations from the National Tuberculosis Controllers Association and CDC. MMWR Recomm Rep 2005 Dec 16;54(RR-15):1-47. [179 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2005 Dec 16

GUIDELINE DEVELOPER(S)

Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

National Tuberculosis Controllers Association/CDC Workgroup on Contact Investigations

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The Centers for Disease Control and Prevention (CDC), their planners, and their content experts wish to disclose they have no financial interests or other relationships with the manufacturers of commercial products, suppliers of commercial services, or commercial supporters. Presentations will not include any discussion of the unlabeled use of a product or a product under investigational use.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site:

- HTML Format

- [Portable Document Format (PDF)](#)

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

A Continuing Education activity is available from the [Centers for Disease Control and Prevention (CDC) Web site](#).

PATIENT RESOURCES

None available

NGC STATUS

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